FOR OHF USE

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0036533

Facility Name: Willow Crest Nsg Pavilion

Address: 515 North Main (Number) Sandwich (City) 60548 (Zip Code)

County: Dekalb

Telephone Number: (815) 786-8426 **Fax #** (815) 786-6487

IDPA ID Number: 363718794001

Date of Initial License for Current Owners: 01/11/91

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/03 to 12/31/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) Richard S. Sgarlata, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nsg Pavilion # 0036533 Report Period Beginning: 01/01/03 Ending: 12/31/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds n/a

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	58	Skilled (SNF)	58	21,170	1
2		Skilled Pediatric (SNF/PED)			2
3	58	Intermediate (ICF)	58	21,170	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	116	TOTALS	116	42,340	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	4,337	2,757	4,013	11,107	8
9	SNF/PED					9
10	ICF	16,578	7,233	761	24,572	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,915	9,990	4,774	35,679	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.27%

D. How many bed-hold days during this year were paid by Public Aid? none (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
n/a

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 8/1/90

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 8/1/90 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 58 and days of care provided 2,773

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/03 Fiscal Year: 12/31/03

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nsg Pavilion # 0036533 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	176,910	17,331	7,822	202,063		202,063		202,063			1
2	Food Purchase		153,974		153,974	(16,352)	137,622	(428)	137,194			2
3	Housekeeping	78,849	20,364		99,213		99,213	(747)	98,466			3
4	Laundry	44,570	17,893		62,463		62,463		62,463			4
5	Heat and Other Utilities			118,329	118,329		118,329	893	119,222			5
6	Maintenance	57,632	42,108	32,725	132,465		132,465	6,433	138,898			6
7	Other (specify):*							488	488			7
8	**TOTAL General Services**	357,961	251,670	158,876	768,507	(16,352)	752,155	6,639	758,794			8
	B. Health Care and Programs											
9	Medical Director			1,200	1,200		1,200		1,200			9
10	Nursing and Medical Records	1,270,488	39,818	87,550	1,397,856		1,397,856	(720)	1,397,136			10
10a	Therapy		608	8,434	9,042		9,042		9,042			10a
11	Activities	56,249	5,473	1,944	63,666		63,666		63,666			11
12	Social Services	25,397		3,727	29,124		29,124		29,124			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,352,134	45,899	102,855	1,500,888		1,500,888	(720)	1,500,168			16
	C. General Administration											
17	Administrative	63,141			63,141		63,141	155,919	219,060			17
18	Directors Fees											18
19	Professional Services			281,378	281,378		281,378	(237,069)	44,309			19
20	Dues, Fees, Subscriptions & Promotions			71,435	71,435		71,435	(49,786)	21,649			20
21	Clerical & General Office Expenses	15,308	3,323	32,169	50,800		50,800	32,968	83,768			21
22	Employee Benefits & Payroll Taxes			260,507	260,507	16,352	276,859	(1,587)	275,272			22
23	Inservice Training & Education			209	209		209		209			23
24	Travel and Seminar			1,700	1,700		1,700	492	2,192			24
25	Other Admin. Staff Transportation			749	749		749		749			25
26	Insurance-Prop.Liab.Malpractice			61,948	61,948		61,948	2,682	64,630			26
27	Other (specify):*							22,833	22,833			27
28	**TOTAL General Administration**	78,449	3,323	710,095	791,867	16,352	808,219	(73,548)	734,671			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,788,544	300,892	971,826	3,061,262		3,061,262	(67,629)	2,993,633			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Willow Crest Nsg Pavilion #0036533 Report Period Beginning: 01/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			120,367	120,367		120,367	81,666	202,033			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			19,628	19,628		19,628	131,206	150,834			32
33	Real Estate Taxes			69,439	69,439		69,439	2,169	71,608			33
34	Rent-Facility & Grounds			480,000	480,000		480,000	(480,000)				34
35	Rent-Equipment & Vehicles			3,883	3,883		3,883	5,972	9,855			35
36	Other (specify):*											36
37	TOTAL Ownership			693,317	693,317		693,317	(258,987)	434,330			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	85,172	65,458	39,493	190,123		190,123	(4,581)	185,542			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			63,510	63,510		63,510		63,510			42
43	Other (specify):*	15,900		98	15,998		15,998	(15,998)				43
44	TOTAL Special Cost Centers	101,072	65,458	103,101	269,631		269,631	(20,579)	249,052			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,889,616	366,350	1,768,244	4,024,210		4,024,210	(347,196)	3,677,014			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nsg Pavilion # 0036533 Report Period Beginning: 01/01/03 Ending: 12/31/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(22,053)	30		9
10	Interest and Other Investment Income	(8,754)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(428)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(48,981)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,319)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(34,803)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (116,338)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(230,857)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (230,857)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (347,196)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Willow Crest Nsg Pavilion

ID# 0036533

Report Period Beginning: 01/01/03

Ending: 12/31/03

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Bank Charges	$ (2,739)	21	1
2	COPE Dues	(1,616)	20	2
3	Discounts Earned	(797)	21	3
4	Marketing Salary	(15,900)	43	4
5	Marketing Expense	(98)	43	5
6				6
7	Franchise Tax (building partnership)	(200)	21	7
8	State Replacement Tax (building partnership)	(3,178)	21	8
9	Amortization (building partnership)	(3,350)	31	9
10	PPA - Pharmacy	(4,392)	39	10
11	PPA - Housekeeping	(747)	03	11
12	PPA - Hospitalization Insurance	(1,587)	22	12
13	PPA - Office Supply	(199)	21	13
14				14
15				15
16				16
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18				18
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98				98
99				99
100				100
101	**Total**	(34,803)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Willow Crest Nsg Pavilion # 0036533 Report Period Beginning: 01/01/03 Ending: 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(428)											(428)	2
3	Housekeeping	(747)											(747)	3
4	Laundry													4
5	Heat and Other Utilities				893								893	5
6	Maintenance				712	5,721							6,433	6
7	Other (specify):*						488						488	7
8	**TOTAL General Services**	(1,175)			1,605	5,721	488						6,639	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			(720)									(720)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**			(720)									(720)	16
	C. General Administration													
17	Administrative					155,919							155,919	17
18	Directors Fees													18
19	Professional Services		900		(237,969)								(237,069)	19
20	Fees, Subscriptions & Promotions	(50,597)			811								(49,786)	20
21	Clerical & General Office Expenses	(8,432)	3,378		32,680	5,342							32,968	21
22	Employee Benefits & Payroll Taxes	(1,587)											(1,587)	22
23	Inservice Training & Education													23
24	Travel and Seminar				492								492	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice				2,682								2,682	26
27	Other (specify):*				5,587		17,246						22,833	27
28	**TOTAL General Administration**	(60,616)	4,278		(195,717)	161,261	17,246						(73,548)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(61,791)	4,278	(720)	(194,112)	166,982	17,734						(67,629)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Willow Crest Nsg Pavilion # 0036533 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(22,053)	100,697		3,022								81,666	30
31	Amortization of Pre-Op. & Org.	(3,350)	3,350											31
32	Interest	(8,754)	137,100		2,860								131,206	32
33	Real Estate Taxes				2,169								2,169	33
34	Rent-Facility & Grounds		(480,000)										(480,000)	34
35	Rent-Equipment & Vehicles				5,972								5,972	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(34,157)	(238,853)		14,023								(258,987)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers	(4,392)		(189)									(4,581)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(15,998)											(15,998)	43
44	**TOTAL Special Cost Centers**	(20,390)		(189)									(20,579)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(116,338)	(234,575)	(909)	(180,089)	166,982	17,734						(347,196)	45

Facility Name & ID Number Willow Crest Nsg Pavilion # 0036533 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		34	Rental Income	$ 480,000	Willow Crest Building LLC		$	$ (480,000)	1
2	V		32	Interest Income	379	Willow Crest Building LLC			(379)	2
3	V		32	Interest Expense		Willow Crest Building LLC		137,479	137,479	3
4	V		21	Franchise Tax		Willow Crest Building LLC		200	200	4
5	V		21	State Replacement Tax		Willow Crest Building LLC		3,178	3,178	5
6	V		19	Accounting Fees		Willow Crest Building LLC		900	900	6
7	V		30	Depreciation		Willow Crest Building LLC		100,697	100,697	7
8	V		31	Amortization		Willow Crest Building LLC		3,350	3,350	8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$ 480,379			$ 245,804	$ * (234,575)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nsg Pavilion # 0036533 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	MEDICAL SUPPLIES	2,852	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	2,132	$ (720)	15
16	V	39	ANCILLARY EXPENSE	750	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	561	(189)	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 3,602			$ 2,693	$ * (909)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nsg Pavilion # 0036533 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V		5	UTILITIES	$	DYNAMIC HEALTH CARE CONS.	100.00%	$ 893	$ 893	15
16	V		6	REPAIRS & MAINT.				712	712	16
17	V		7	EMP.BEN. - GEN. SERVICES						17
18	V		19	PROFESSIONAL FEES				2,431	2,431	18
19	V		20	DUES AND SUBSCRIPTIONS				811	811	19
20	V		21	CLERICAL & GENERAL				32,680	32,680	20
21	V		24	SEMINARS AND TRAVEL				492	492	21
22	V		26	INSURANCE				2,682	2,682	22
23	V		27	EMP.BEN. - GEN. ADMIN.				5,587	5,587	23
24	V		30	DEPRECIATION				3,022	3,022	24
25	V		32	INTEREST				2,860	2,860	25
26	V		33	REAL ESTATE TAXES				2,169	2,169	26
27	V		35	EQUIPMENT RENTAL				5,972	5,972	27
28	V									28
29	V		19	BOOKKEEPING SERVICES	240,400				(240,400)	29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$ 240,400			$ 60,311	$ * (180,089)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nsg Pavilion # 0036533 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V		6	MAINT. CMP. - D. NEHMER	$	DYNAMIC HEALTH CARE CONS.	100.00%	$ 5,721	$ 5,721	15
16	V		17	ADMIN. CMP. - M. MAUER				31,852	31,852	16
17	V		17	ADMIN. CMP. - M. AARON				46,809	46,809	17
18	V		17	ADMIN. CMP. - F. AARON				33,976	33,976	18
19	V		17	ADMIN. CMP. - S. GOLDSTEIN						19
20	V		17	ADMIN. CMP. - S. KOPLIN				8,801	8,801	20
21	V		17	ADMIN. CMP. - D. MAGAFAS				8,806	8,806	21
22	V		17	ADMIN. CMP. - S. BOGEN						22
23	V		17	ADMIN. CMP. - S. LEVY				10,985	10,985	23
24	V		17	ADMIN. CMP. - HOWARD ALTER						24
25	V		17	ADMIN. CMP. - NON-OWNER				14,690	14,690	25
26	V		21	CLERICAL CMP. - S. AARON				5,342	5,342	26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$ 166,982	$ * 166,982	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nsg Pavilion # 0036533 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	7	EMP. BEN.- D. NEHMER	$	DYNAMIC HEALTH CARE CONS.	100.00%	$ 488	$ 488	15
16	V	27	EMP. BEN.- M. MAUER				1,011	1,011	16
17	V	27	EMP. BEN.- M. AARON				1,558	1,558	17
18	V	27	EMP. BEN.- F. AARON				5,701	5,701	18
19	V	27	EMP. BEN.- S. GOLDSTEIN						19
20	V	27	EMP. BEN.- S. KOPLIN				3,330	3,330	20
21	V	27	EMP. BEN.- D. MAGAFAS				774	774	21
22	V	27	EMP. BEN.- S. BOGEN						22
23	V	27	EMP. BEN.- S. LEVY				1,589	1,589	23
24	V	27	EMP. BEN.- HOWARD ALTER						24
25	V	27	EMP. BEN.- NON-OWNER				2,231	2,231	25
26	V	27	EMP. BEN. - S. AARON				1,052	1,052	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 17,734	$ * 17,734	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nsg Pavilion # 0036533 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10A	THERAPY	$ 5,014	DYNAMIC REHAB CONSULTANTS, L.L.C.	100.00%	$ 5,014	$	15
16	V	19	PROFESSIONAL FEES	3,500	DYNAMIC REHAB CONSULTANTS, L.L.C.	100.00%	3,500		16
17	V	22	EMPLOYEE BENEFITS		DYNAMIC REHAB CONSULTANTS, L.L.C.	100.00%			17
18	V	39	ANCILLARY SERVICES	8,041	DYNAMIC REHAB CONSULTANTS, L.L.C.	100.00%	8,041		18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 16,555			$ 16,555	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nsg Pavilion # 0036533 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nsg Pavilion # 0036533 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nsg Pavilion # 0036533 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nsg Pavilion # 0036533 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nsg Pavilion # 0036533 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	Marshall Mauer	Owner	Administrative	10.78%	See Attached	3.41	6.82%	Dynamic All	$ 31,852	17-07	1
2	Maurice Aaron	Owner	Administrative	23.79%	See Attached	3.82	7.64%	Dynamic All	46,809	17-07	2
3	Fred Aaron	Owner	Administrative	13.10%	See Attached	8.00	17.78%	Dynamic All	33,976	17-07	3
4	Sue Koplin	Owner	Administrative	0.56%	See Attached	5.09	12.74%	Dynamic All	8,801	17-07	4
5	Diania Magafas	Owner	Administrative	0.56%	See Attached	5.12	11.37%	Dynamic All	8,806	17-07	5
6	Dennis Nehmer	Owner	Maintenance	0.56%	See Attached	3.82	9.56%	Dynamic All	5,721	06-07	6
7	Sharon Aaron	Owner	Clerical	0.56%	See Attached	3.41	8.53%	Dynamic All	5,342	21-07	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 141,307		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Willow Crest Nsg Pavilion # 0036533 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nsg Pavilion # 0036533 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: LINCOLN MEDICAL SUPPLIES, INC.
Street Address: 3359 W. MAIN STREET
City / State / Zip Code: SKOKIE, IL. 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	MEDICAL SUPPLIES	DIRECT ALLOCATION						2,132	1
2	39	ANCILLARY EXPENSE	DIRECT ALLOCATION						561	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 2,693	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nsg Pavilion # 0036533 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTH CARE CONS.
Street Address: 3359 W. MAIN STREET
City / State / Zip Code: SKOKIE, IL. 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	423,801	12	$ 10,611	$	35,679	$ 893	1
2	6	REPAIRS & MAINT.	PATIENT DAYS	423,801	12	8,462		35,679	712	2
3	7	EMP.BEN. - GEN. SERVICES	PATIENT DAYS	423,801	12			35,679		3
4	19	PROFESSIONAL FEES	PATIENT DAYS	423,801	12	28,879		35,679	2,431	4
5	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	423,801	12	9,628		35,679	811	5
6	21	CLERICAL & GENERAL	PATIENT DAYS	423,801	12	388,179	279,093	35,679	32,680	6
7	24	SEMINARS AND TRAVEL	PATIENT DAYS	423,801	12	5,844		35,679	492	7
8	26	INSURANCE	PATIENT DAYS	423,801	12	31,856		35,679	2,682	8
9	27	EMP.BEN. - GEN. ADMIN.	PATIENT DAYS	423,801	12	66,362		35,679	5,587	9
10	30	DEPRECIATION	PATIENT DAYS	423,801	12	35,898		35,679	3,022	10
11	32	INTEREST	PATIENT DAYS	423,801	12	33,975		35,679	2,860	11
12	33	REAL ESTATE TAXES	PATIENT DAYS	423,801	12	25,761		35,679	2,169	12
13	35	EQUIPMENT RENTAL	PATIENT DAYS	423,801	12	70,935		35,679	5,972	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 716,390	$ 279,093		$ 60,311	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nsg Pavilion # 0036533 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTH CARE CONS.
Street Address: 3359 W. MAIN STREET
City / State / Zip Code: SKOKIE, IL. 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	MAINT. CMP. - D. NEHMER	WGHTD. AVG. HOURS	40	9	59,901	59,901	4	5,721	1
2	17	ADMIN. CMP. - M. MAUER	WGHTD. AVG. HOURS	40	11	373,726	373,726	3	31,852	2
3	17	ADMIN. CMP. - M. AARON	WGHTD. AVG. HOURS	40	9	490,141	490,141	4	46,809	3
4	17	ADMIN. CMP. - F. AARON	WGHTD. AVG. HOURS	45	6	191,118	191,118	8	33,976	4
5	17	ADMIN. CMP. - S. GOLDSTEIN	WGHTD. AVG. HOURS	40	3	49,500	49,500			5
6	17	ADMIN. CMP. - S. KOPLIN	WGHTD. AVG. HOURS	40	7	69,097	69,097	5	8,801	6
7	17	ADMIN. CMP. - D. MAGAFAS	WGHTD. AVG. HOURS	45	9	77,417	77,417	5	8,806	7
8	17	ADMIN. CMP. - S. BOGEN	WGHTD. AVG. HOURS	11	2	40,545	40,545			8
9	17	ADMIN. CMP. - S. LEVY	WGHTD. AVG. HOURS	45	11	128,818	128,818	4	10,985	9
10	17	ADMIN. CMP. - HOWARD ALT	WGHTD. AVG. HOURS	40	1	12,000	12,000			10
11	17	ADMIN. CMP. - NON-OWNER	WGHTD. AVG. HOURS	45	11	153,735	153,735	4	14,690	11
12	21	CLERICAL CMP. - S. AARON	WGHTD. AVG. HOURS	40	11	62,676	62,676	3	5,342	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,708,674	$ 1,708,675		$ 166,982	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nsg Pavilion # 0036533 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTH CARE CONS.
Street Address: 3359 W. MAIN STREET
City / State / Zip Code: SKOKIE, IL. 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	7	EMP. BEN.- D. NEHMER	WGHTD. AVG. HOURS	40	9	5,106		4	488	1
2	27	EMP. BEN.- M. MAUER	WGHTD. AVG. HOURS	40	11	11,858		3	1,011	2
3	27	EMP. BEN.- M. AARON	WGHTD. AVG. HOURS	40	9	16,312		4	1,558	3
4	27	EMP. BEN.- F. AARON	WGHTD. AVG. HOURS	45	6	32,071		8	5,701	4
5	27	EMP. BEN.- S. GOLDSTEIN	WGHTD. AVG. HOURS	40	3	26,160				5
6	27	EMP. BEN.- S. KOPLIN	WGHTD. AVG. HOURS	40	7	26,142		5	3,330	6
7	27	EMP. BEN.- D. MAGAFAS	WGHTD. AVG. HOURS	45	9	6,801		5	774	7
8	27	EMP. BEN.- S. BOGEN	WGHTD. AVG. HOURS	11	2	3,320				8
9	27	EMP. BEN.- S. LEVY	WGHTD. AVG. HOURS	45	11	18,630		4	1,589	9
10	27	EMP. BEN.- HOWARD ALTER	WGHTD. AVG. HOURS	40	1	4,292				10
11	27	EMP. BEN.- NON-OWNER	WGHTD. AVG. HOURS	45	11	23,348		4	2,231	11
12	27	EMP. BEN. - S. AARON	WGHTD. AVG. HOURS	40	11	12,346		3	1,052	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 186,386	$		$ 17,734	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nsg Pavilion # 0036533 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC REHAB CONSULTANTS, L.L.C.
Street Address: 3359 W. MAIN STREET
City / State / Zip Code: SKOKIE, IL. 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10A	THERAPY	DIRECT ALLOCATION						5,014	1
2	19	PROFESSIONAL FEES	DIRECT ALLOCATION						3,500	2
3	22	EMPLOYEE BENEFITS	DIRECT ALLOCATION							3
4	39	ANCILLARY SERVICES	DIRECT ALLOCATION						8,041	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 16,555	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nsg Pavilion # 0036533 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nsg Pavilion # 0036533 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nsg Pavilion # 0036533 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nsg Pavilion # 0036533 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nsg Pavilion # 0036533 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	American National Bank		X	Mortgage			$ 3,350,000	$ 1,955,308			$ 137,479	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	Bank One		X	Line of Credit				200,000	12/31/04	prime	9,772	6
7	Bank One		X	Working Capital	$3,333.00	7/31/02	200,000	140,000	12/01/04	prime+1%	8,406	7
8	See Supplemental Schedule										4,310	8
9	TOTAL Facility Related				$3,333.00		$ 3,550,000	$ 2,295,308			$ 159,967	9
	B. Non-Facility Related*											
10												10
11	interest income		X								(8,754)	11
12	interest income - bldg co.										(379)	12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (9,133)	14
15	TOTALS (line 9+line14)						$ 3,550,000	$ 2,295,308			$ 150,834	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ none Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Willow Crest Nsg Pavilion # 0036533 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Diamond Insurance		X	Liability Insurance Financing			$	$			$ 1,450	8
9	Dynamic Healthcare Alloc.	X									2,860	9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										4,310	14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Willow Crest Nsg Pavilion # 0036533 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2002 report.	$	54,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	62,608	2
3. Under or (over) accrual (line 2 minus line 1).	$	8,608	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$	63,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	71,608	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1998	48,905	8
	1999	49,489	9
	2000	50,345	10
	2001	52,352	11
	2002	60,439	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

2003 accrual = 2002 taxes x 1.05
60479 X 1.05 = 63, 503 (rounded)
allocation from Dynamic = 2169

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Willow Crest Nsg Pavilion COUNTY Dekalb

FACILITY IDPH LICENSE NUMBER 0036533

CONTACT PERSON REGARDING THIS REPORT : Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	19-26-433-024	Long Term Care Property	$ 60,439.72	$ 60,439.72
2.	10-23-404-059-0000	Home Office Allocation	$ 26,274.55	$ 2,212.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 86,714.27	$ 62,651.72

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? XX YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Willow Crest Nsg Pavilion COUNTY Dekalb

FACILITY IDPH LICENSE NUMBER 0036533

CONTACT PERSON REGARDING THIS REPORT : Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Willow Crest Nsg Pavilion # 0036533 Report Period Beginning: 01/01/03 Ending: 12/31/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 38,430 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1998	$ 327,859	1
2					2
3	TOTALS			$ 327,859	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nsg Pavilion # 0036533 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1990	21,410		20	1,071	1,071	14,456	9
10	Various			1991	9,997		20	-		9,918	10
11	Various			1992	4,279		20	214	214	2,470	11
12	Various			1993	26,868		20	1,344	(1,344)	13,942	12
13	Various			1994	8,312		20	416	416	3,968	13
14	Various			1995	3,234		20	162	162	1,382	14
15	Various			1996	17,411		20	870	870	6,240	15
16	Various			1997	68,499		20	3,425	3,425	20,664	16
17	Various			1998	31,645		20	1,583	1,583	8,288	17
18	Various			1999	147,088		20	7,299	7,299	32,663	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Willow Crest Nsg Pavilion # 0036533 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)		2,544,733	65,250		62,250	(3,000)	325,969	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)		37,346	958		1,067	109	11,026	68
69	Financial Statement Depreciation			27,387			(27,387)		69
70	TOTAL (lines 4 thru 69)		$ 2,920,822	$ 93,595		$ 79,701	$ (16,582)	$ 450,986	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Willow Crest Nsg Pavilion # 0036533 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,920,822	$ 93,595		$ 79,701	$ (13,894)	$ 450,986	1
2	Roof Renovation	2000	23,155		20	1,158	1,158	4,632	2
3	Shower Remodeling	2000	673		20	34	34	135	3
4	Shower Remodeling	2000	638		20	32	32	128	4
5	Fire Doors	2000	1,939		20	97	97	388	5
6	Tile & Cove Base	2000	838		20	42	42	165	6
7	Tile	2000	1,791		20	90	90	352	7
8	Cove Base	2000	462		20	23	23	90	8
9	Water Heater Repair	2000	2,081		20	104	104	399	9
10	Security Cameras	2000	1,925		20	96	96	369	10
11	Cubicle Hooks	2000	112		20	6	6	22	11
12	Tiles	2000	507		20	25	25	97	12
13	Cubicle Tracks&Curta	2000	507		20	25	25	97	13
14	Tile	2000	1,912		20	96	96	367	14
15	Shower Remodeling	2000	405		20	20	20	76	15
16	Tile	2000	699		20	35	35	131	16
17	Buzzers	2000	175		20	9	9	34	17
18	Water Tank Repair	2000	667		20	33	33	125	18
19	Elevator Door Edge	2000	2,270		20	114	114	417	19
20	Tile	2000	210		20	11	11	38	20
21	Boiler Repair	2000	458		20	23	23	82	21
22	Kick Plates	2000	392		20	20	20	71	22
23	Security Monitor	2000	290		20	15	15	54	23
24	Bathroom Tile	2000	30,000		20	1,500	1,500	5,375	24
25	Bathroom Tile	2000	15,000		20	750	750	2,688	25
26	Dining Room Tiles	2000	4,500		20	225	225	806	26
27	Roof Repair	2000	1,425		20	71	71	267	27
28	Sprinkler Repair	2000	1,625		20	81	81	285	28
29	Lighting	2000	1,770		20	89	89	311	29
30	Water Pump	2000	1,567		20	78	78	268	30
31	Tile	2000	1,792		20	90	90	307	31
32	Fixtures	2000	1,587		20	79	79	264	32
33	Cove Base	2000	318		20	16	16	53	33
34	TOTAL (lines 1 thru 33)		$ 3,022,512	$ 93,595		$ 84,788	$ (8,807)	$ 469,879	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Willow Crest Nsg Pavilion # 0036533 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,022,512	$ 93,595		$ 84,788	$ (8,807)	$ 469,879	1
2	Tile	2000	2,599		20	130	130	433	2
3	Faucets	2000	699		20	35	35	117	3
4	Bathroom Sinks	2000	538		20	27	27	90	4
5	Bathroom Sinks&Fauce	2000	1,072		20	54	54	179	5
6	Tile	2000	5,425		20	271	271	927	6
7	Cove Base	2000	837		20	42	42	137	7
8	Wall Guards	2000	589		20	29	29	95	8
9	Wall Borders	2000	1,772		20	89	89	288	9
10	Sound System	2000	840		20	42	42	137	10
11	Tile	2000	307		20	15	15	51	11
12	Tile	2000	205		20	10	10	34	12
13	Defrost Clock	2000	725		20	36	36	115	13
14	Fire Panels	2000	2,887		20	144	144	457	14
15	Wall Borders	2000	1,828		20	91	91	289	15
16	Carpeting	2000	5,270		20	264	264	857	16
17	Tiling & Drywall	2000	5,900		20	295	295	910	17
18	Cooler Repair	2000	719		20	36	36	111	18
19	Door	2000	320		20	16	16	49	19
20	Wallpaper	2000	3,919		20	196	196	637	20
21	Wallpaper	2000	3,066		20	153	153	511	21
22	Parking Lot Paving	2000	8,775		20	439	439	1,317	22
23	Remodel Stairwell	2001	1,080		20	54	54	126	23
24	Doors & Refinishing	2001	13,510		20	676	676	1,689	24
25	Doors & Refinishing	2001	1,725		20	86	86	209	25
26	Doors & Refinishing	2001	100		20	5	5	12	26
27	Doors & Refinishing	2001	1,925		20	96	96	233	27
28	Doors & Refinishing	2001	900		20	45	45	109	28
29	Doors & Refinishing	2001	300		20	15	15	35	29
30	Doors & Refinishing	2001	300		20	15	15	35	30
31	Doors & Refinishing	2001	1,300		20	65	65	152	31
32	Doors & Refinishing	2001	900		20	45	45	105	32
33	Doors & Refinishing	2001	600		20	30	30	70	33
34	TOTAL (lines 1 thru 33)		$ 3,093,444	$ 93,595		$ 88,334	$ (5,261)	$ 480,395	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Willow Crest Nsg Pavilion # 0036533 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 3,093,444	$ 93,595		$ 88,334	$ (5,261)	$ 480,395	1
2	Bathroom Imprvmnt	2001	641		20	32	32	77	2
3	Dining Rm Tile	2001	720		20	36	36	87	3
4	Bathroom Faucet	2001	725		20	36	36	88	4
5	Bathroom Fixtures	2001	2,434		20	122	122	294	5
6	Drywall Mat'L For 2F	2001	375		20	19	19	46	6
7	Door Frame	2001	315		20	16	16	39	7
8	Tile	2001	424		20	21	21	51	8
9	Doors	2001	1,096		20	55	55	133	9
10	Door Hinges	2001	237		20	12	12	29	10
11	Doors	2001	392		20	20	20	47	11
12	Tile	2001	198		20	10	10	24	12
13	Bathroom Fixtures	2001	228		20	11	11	28	13
14	Bathroom Fixtures	2001	821		20	41	41	99	14
15	Bathroom Floor	2001	1,610		20	81	81	188	15
16	Wall Guard	2001	715		20	36	36	84	16
17	Wall Covering	2001	3,920		20	196	196	457	17
18	Bathroom Floor	2001	3,283		20	164	164	383	18
19	Light Fixtures	2001	337		20	17	17	40	19
20	Bathroom Fixtures	2001	407		20	20	20	48	20
21	Bathroom Fixtures	2001	350		20	18	18	41	21
22	Door	2001	495		20	25	25	65	22
23	Door	2001	42		20	2	2	5	23
24	Door	2001	171		20	9	9	22	24
25	Repair Concrete In R	2001	260		20	13	13	33	25
26	Carpet For Rehab Rm	2001	493		20	25	25	62	26
27	Repair Ifre Alarm Sy	2001	633		20	32	32	79	27
28	Fixtures For Rehab R	2001	192		20	10	10	24	28
29	Door Locks	2001	367		20	18	18	46	29
30	Fixtures For Rehab	2001	170		20	9	9	22	30
31	Fixtures For Rehab R	2001	527		20	26	26	66	31
32	Fixtures For Rehab R	2001	407		20	20	20	51	32
33	Door Frames	2001	315		20	16	16	40	33
34	TOTAL (lines 1 thru 33)		$ 3,116,744	$ 93,595		$ 89,502	$ (4,093)	$ 483,193	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Willow Crest Nsg Pavilion # 0036533 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 3,116,744	$ 93,595		$ 89,502	$ (4,093)	$ 483,193	1
2	Ceiling Tile	2001	170		20	9	9	22	2
3	Kick Plates For Drs	2001	1,591		20	80	80	199	3
4	Nurses Station	2001	9,066		20	453	453	1,134	4
5	Fixtures	2001	408		20	20	20	51	5
6	Bathroom Floor	2001	1,375		20	69	69	167	6
7	Wood Strips For Ther	2001	3,929		20	196	196	475	7
8	Carpeting	2001	547		20	27	27	66	8
9	Repair Of Water Soft	2001	2,418		20	121	121	363	9
10	Door	2001	1,295		20	65	65	190	10
11	Repair Water Heater	2001	1,956		20	98	98	286	11
12	Flooring	2001	2,104		20	105	105	306	12
13	Flooring	2001	2,517		20	126	126	368	13
14	Install Magnetics Lo	2001	589		20	29	29	81	14
15	Doors	2001	328		20	16	16	45	15
16	Store Room Lock	2001	216		20	11	11	30	16
17	Door Handles	2001	309		20	15	15	42	17
18	Door Handles	2001	141		20	7	7	19	18
19	Shelves	2001	717		20	36	36	99	19
20	Nurses Station	2001	9,066		20	453	453	1,209	20
21	Shelving	2001	480		20	24	24	64	21
22	Door Kick Plates	2001	229		20	11	11	30	22
23	Doors	2001	1,025		20	51	51	137	23
24	Drywall Halls, New C	2001	2,650		20	133	133	354	24
25	Stain For Doors	2001	228		20	11	11	30	25
26	Signs	2001	744		20	37	37	96	26
27	Custom Wall Cabinets	2001	9,266		20	463	463	1,197	27
28	Doors	2001	429		20	21	21	55	28
29	Woodstrips	2001	268		20	13	13	30	29
30	Wallpaper	2001	1,980		20	99	99	223	30
31	Foot Rails	2001	1,962		20	98	98	221	31
32	Wallcovering	2001	2,793		20	140	140	314	32
33	Wallpaper	2001	4,500		20	225	225	506	33
34	TOTAL (lines 1 thru 33)		$ 3,182,040	$ 93,595		$ 92,764	$ (831)	$ 491,602	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Willow Crest Nsg Pavilion # 0036533 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 3,182,040	$ 93,595		$ 92,764	$ (831)	$ 491,602	1
2	2Nd Floor Bulbs	2001	195		20	10	10	23	2
3	Doors & Refinishing	2001	1,500		20	75	75	169	3
4	Signs	2001	1,938		20	97	97	210	4
5	Wallpaper & Plaster	2001	3,400		20	170	170	368	5
6	Elevator Voice Activ	2001	1,500		20	75	75	163	6
7	Door Locks	2001	1,705		20	85	85	185	7
8	Door Wiring	2001	3,000		20	150	150	313	8
9	Remodeling - 2Fl	2001	13,885		20	694	694	1,447	9
10	Plumbing	2001	867		20	43	43	123	10
11	Carpeting	2002	15,541		20	2,220	2,220	4,255	11
12	Temperature Control	2002	627		20	63	63	115	12
13	Temperature Switch	2002	560		20	56	56	103	13
14	Monitoring Panel	2002	937		20	94	94	172	14
15	Tiling	2002	963		20	48	48	84	15
16	Wallpaper	2002	8,570		20	2,143	2,143	8,570	16
17	Wallcovering	2002	1,182		20	296	296	1,182	17
18	Ceiling Tile	2002	919		20	46	46	80	18
19	Storage Tank	2002	2,199		20	220	220	385	19
20	Kitchen Lights	2002	1,124		20	112	112	187	20
21	Cove Base	2002	728		20	73	73	121	21
22	Wall Mount Cooler	2002	530		20	53	53	84	22
23	Smoke Detector	2002	1,872		20	187	187	281	23
24	Doors	2002	1,289		20	64	64	86	24
25	Lighting	2002	352		20	35	35	47	25
26	Lighting	2002	517		20	52	52	69	26
27	Roofing	2002	4,265		20	427	427	604	27
28	Wall Heaters & A/C	2002	5,259		20	526	526	701	28
29	Light Fixtures	2002	1,132		20	113	113	123	29
30	Heating	2002	588		20	59	59	88	30
31	Fire Alarm System	2002	730		20	104	104	200	31
32	Alarm System Repair	2002	563		20	80	80	141	32
33	Alarm System Repair	2002	563		20	80	80	141	33
34	TOTAL (lines 1 thru 33)		$ 3,261,040	$ 93,595		$ 101,314	$ 7,719	$ 512,422	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Willow Crest Nsg Pavilion # 0036533 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 3,261,040	$ 93,595		$ 101,314	$ 7,719	$ 512,422	1
2	Heating	2002	586		20	59	59	88	2
3	Phone System	2002	510		20	51	51	102	3
4	Walk-In Cooler And Condensing Unit	2003	3,589		20	329	329	329	4
5	Roof Repairs	2003	2,480		20	186	186	186	5
6	Custom Built-In Wardrobe Dresser Units	2003	63,420		20	3,700	3,700	3,700	6
7	**Elevator Handrails, Window Treatments & Curtains	2003	6,476		20	324	324	324	7
8	**Sealcoating Parking Lot	2003	2,250		20	75	75	75	8
9	**Hot Water System	2003	1,387		20	35	35	35	9
10	** Added After 6/30/03 Capital Report								10
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31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,341,738	$ 93,595		$ 106,073	$ 12,478	$ 517,261	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Willow Crest Nsg Pavilion # 0036533 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 3,341,738	$ 93,595		$ 106,073	$ 12,478	$ 517,261	1
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,341,738	$ 93,595		$ 106,073	$ 12,478	$ 517,261	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Willow Crest Nsg Pavilion # 0036533 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 3,341,738	$ 93,595		$ 106,073	$ 12,478	$ 517,261	1
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31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,341,738	$ 93,595		$ 106,073	$ 12,478	$ 517,261	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Willow Crest Nsg Pavilion # 0036533 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 3,341,738	$ 93,595		$ 106,073	$ 12,478	$ 517,261	1
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,341,738	$ 93,595		$ 106,073	$ 12,478	$ 517,261	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Willow Crest Nsg Pavilion # 0036533 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		$ 3,341,738	$ 93,595		$ 106,073	$ 12,478	$ 517,261	1
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32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,341,738	$ 93,595		$ 106,073	$ 12,478	$ 517,261	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Willow Crest Nsg Pavilion # 0036533 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1998		$ 2,544,733	$ 65,250		$ 62,250	$ (3,000)	$ 325,969	4
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	Improvement Type**										
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35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-BLDG, Line 70 for total

Facility Name & ID Number Willow Crest Nsg Pavilion # 0036533 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
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67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,544,733	$ 65,250		$ 62,250	$ (3,000)	$ 325,969	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Willow Crest Nsg Pavilion # 0036533 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Dyn. Alloc		1993		$ 37,346	$ 958		$ 1,067	$ 109	$ 11,026	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number Willow Crest Nsg Pavilion # 0036533 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 37,346	$ 958		$ 1,067	$ 109	$ 11,026	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Willow Crest Nsg Pavilion # 0036533 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 839,910	$ 87,127	$ 84,757	$ (2,370)	10	$ 550,407	71
72	Current Year Purchases	42,644	40,887	7,093	(33,794)	10	7,093	72
73	Fully Depreciated Assets	38,315				10	38,315	73
74								74
75	TOTALS	$ 920,869	$ 128,014	$ 91,850	$ (36,164)		$ 595,815	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	DODGE WAGON	1994	$ 27,533	$ 1,675	$ 2,753	$ 1,078	5	$ 25,925	76
77	Dynamic Allocation	Dynamic Auto allocation		4,739	802	1,357	555	5	4,645	77
78										78
79										79
80	TOTALS			$ 32,272	$ 2,477	$ 4,110	$ 1,633		$ 30,570	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,622,738	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 224,086	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 202,033	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (22,053)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,143,646	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 9,855 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Willow Crest Nsg Pavilion # 0036533 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nsg Pavilion # 0036533 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 01	937 hrs	$ 26,340		$ 23,352	$	937	$ 49,692	1
2	Licensed Speech and Language Development Therapist	39 - 01	1594 hrs	7,871		333		1,594	8,204	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 01	186 hrs	50,961		13,896		186	64,857	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				58,683		58,683	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental					1,912	6,775		8,687	13
14	TOTAL			$ 85,172		$ 39,493	$ 65,458	2,717	$ 190,123	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nsg Pavilion # 0036533 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/03 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 101,450	$ 149,748	1
2	Cash-Patient Deposits	31,395	31,395	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	525,591	525,591	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	27,677	27,677	6
7	Other Prepaid Expenses	460	460	7
8	Accounts Receivable (owners or related parties)	122,355	224,955	8
9	Other(specify): See Attached Schedule	6,731	324	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 815,659	$ 960,150	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		327,859	13
14	Buildings, at Historical Cost		2,544,733	14
15	Leasehold Improvements, at Historical Cost	722,035	722,035	15
16	Equipment, at Historical Cost	524,561	930,561	16
17	Accumulated Depreciation (book methods)	(571,169)	(1,239,674)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	6,000	6,000	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(6,000)	(6,000)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule		16,610	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 675,427	$ 3,302,124	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,491,086	$ 4,262,274	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 203,830	$ 203,831	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	37,788	37,788	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	180,060	180,060	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,285	2,285	31
32	Accrued Real Estate Taxes(Sch.IX-B)	63,000	63,000	32
33	Accrued Interest Payable		7,683	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	7,401	7,401	35
	Other Current Liabilities(specify):			
36	See Attached Schedule			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 494,364	$ 502,048	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	340,000	340,000	39
40	Mortgage Payable		1,955,308	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 340,000	$ 2,295,308	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 834,364	$ 2,797,356	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 656,722	$ 1,464,918	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,491,086	$ 4,262,274	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Willow Crest Nsg Pavilion # 0036533 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 501,332	1
2	Restatements (describe):		2
3	State Replacement Tax	(500)	3
4	Rounding Error	4	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 500,836	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	155,886	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 155,886	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 656,722	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nsg Pavilion # 0036533 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,139,024	1
2	Discounts and Allowances for all Levels	(542,192)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,596,832	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	466,950	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 466,950	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	81,437	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	19,135	19
20	Radiology and X-Ray	897	20
21	Other Medical Services	5,294	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 106,763	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	8,754	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 8,754	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	797	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 797	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,180,096	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	768,507	31
32	Health Care	1,500,888	32
33	General Administration	791,867	33
	B. Capital Expense		
34	Ownership	693,317	34
	C. Ancillary Expense		
35	Special Cost Centers	206,121	35
36	Provider Participation Fee	63,510	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,024,210	40
41	**Income before Income Taxes (line 30 minus line 40)****	155,886	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 155,886	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** cash basis **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Willow Crest Nsg Pavilion # 0036533 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,917	2,086	$ 54,614	$ 26.18	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,335	10,180	234,204	23.01	3
4	Licensed Practical Nurses	14,991	16,028	341,815	21.33	4
5	Nurse Aides & Orderlies	49,945	52,138	606,848	11.64	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	2,718	2,953	85,172	28.84	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,943	2,120	26,594	12.54	9
10	Activity Assistants	4,375	4,414	29,655	6.72	10
11	Social Service Workers	2,375	2,467	25,397	10.29	11
12	Dietician					12
13	Food Service Supervisor	1,911	2,063	31,866	15.45	13
14	Head Cook	4,009	4,283	48,230	11.26	14
15	Cook Helpers/Assistants	13,356	13,931	96,814	6.95	15
16	Dishwashers					16
17	Maintenance Workers	3,240	3,553	57,632	16.22	17
18	Housekeepers	11,271	11,846	78,849	6.66	18
19	Laundry	6,614	6,928	44,570	6.43	19
20	Administrator	1,806	2,086	63,141	30.27	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	956	1,072	15,308	14.28	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,528	2,830	33,007	11.66	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	956	1,032	15,900	15.41	33
34	TOTAL (lines 1 - 33)	134,246	142,010	$ 1,889,616 *	$ 13.31	34

SEE ACCOUNTANTS' COMPILATION REPORT

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	245	$ 7,822	01-03	35
36	Medical Director	24	1,200	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	121	4,820	10-03	39
40	Physical Therapy Consultant	119	4,243	10a-03	40
41	Occupational Therapy Consultant	57	2,948	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	36	1,243	10a-03	43
44	Activity Consultant	41	1,944	11-03	44
45	Social Service Consultant	33	1,898	12-03	45
46	Other(specify)				46
47	Psych-social	39	1,829	12-03	47
48					48
49	TOTAL (lines 35 - 48)	715	$ 27,947		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	452	14,806	10-03	51
52	Nurse Aides	2,196	67,924	10-03	52
53	TOTAL (lines 50 - 52)	2,648	$ 82,730		53

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Willow Crest Nsg Pavilion # 0036533 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Pam Ingold	Administrator	0	$ 63,141
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 63,141

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Sachnoff & Weaver	Legal	$ 5,482
Frost, Ruttenberg & Rothblatt	Accounting	17,145
Krupnik, Boker, Kagda & Brooks	Accounting	1,111
Dynamic Healthcare	Bookkeeping Services	240,400
Health Data Systems	Data Processing	4,640
Robinson & Associates	Computer Services	3,790
Dynamic Rehab	Billing & Bookkeeping	3,500
Dart Chart System	Medicare Consultant	2,556
Personnel Planners	Unemployment Consult	740
Econocare	Purchasing Consultant	2,014
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 281,378

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 54,392
Unemployment Compensation Insurance	23,519
FICA Taxes	139,467
Employee Health Insurance	37,335
Employee Meals	16,352
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	4,207
TOTAL (agree to Schedule V, line 22, col.8)	$ 275,272

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	14,978
Health Care Worker Background Check	199
(Indicate # of checks performed 28)	
Licenses & Permits	779
Advertising	48,981
Dues & Subscriptions	4,682
Allocation Dynamic Healthcare	811
Less: Public Relations Expense	( )
Non-allowable advertising	(48,981)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 21,649

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,700
Allocation Dynamic Healthcare	492
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,192

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nsg Pavilion # 0036533 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	None		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nsg Pavilion # 0036533 Report Period Beginning: 01/01/03 Ending: 12/31/03

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL council on LTC: 6083**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,040** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **n/a**

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **No** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **63,510**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **16,352** Has any meal income been offset against related costs? **No** Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.